MARKET SQUARE DENTAL

MEDICAL HISTORY UPDATE

NAME: _____DOB: _____

FULL ADDRESS: _____

EMAIL: _____

HOME PHONE#: _____ CELL PHONE #: _____

How would you like to receive appointment reminders? Email or Text (please circle preference/consent)

1. Has there been any changes in your health, such as serious illnesses, hospitalizations, or new allergies?
   Yes No Not Sure
2. Are you taking any new medications or has there been any changes in your medications? If so, explain.
   Yes No Not Sure
3. Have you had a new heart problem diagnosed or had any changes in an existing heart problem?
   Yes No Not Sure
4. When was your last medical check up? _____
5. Were any problems identified? Yes No Not Sure
6. If yes, please explain._____
7. Have you had an orthopedic joint (hip, knee, elbow, finger) replacement?
   Date: _____ If yes, have you had any complications? Yes/No
8. Are you taking any medications for osteoporosis (Fosomax, Actenol, Atelvia, Bonivia, Reclast, Prolia)
   Yes/No
9. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes/No
10. **Women Only:** Are you pregnant? Yes/No Nursing? Yes/No
    Are you using birth control? Yes/No
11. Additional information and/or changes to your health, not listed above.

    _____

    Reviewed by Doctor/Staff:_____

    Signature of Patient/Legal Guardian: _____Date:_____